Division of Health Care Facilities

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	TN7102	A. BUILDING: _____ B. WING _____	12/11/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
KINDRED NURSING AND REHABILITATION-M/	278 DRY VALLEY RD ALGOOD, TN 38501

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETE DATE
N 000	Initial Comments A licensure survey and complaint investigation (#32677, #32825, #32876, and #32959) survey was conducted from December 9, through December 11, 2013, at Kindred Nursing and Rehabilitation - Masters. No deficiencies were cited related to the complaints (#32677, #32825, #32876, and #32959) under Chapter 1200-08-06 Standards For Nursing Homes.	N 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE: Sylvia J. Burton — TITLE: Executive Dir — (X6) DATE: 12/3/13